17 Research Drive
Amherst MA 01002
office@doctorkate.net

Atkinson
Family Practice

P: (413) 549-8400
F: (413) 549-8409
www.atkinsonfamilypractice.com

HIPAA

Contact Information/Privacy Consent

Patient Name: _____ DOB:_____ Preferred Pronoun: _____

Address: _____ City _____ State _____ Zip _____

	May we leave a message and/or medical info?	Which number is primary for messages?
Phone (Home) _____	**Y / N**	☐
(Work) _____	**Y / N**	☐
(Cell) _____	**Y / N**	☐

How do you want to receive a reminder of an upcoming appointment?

Text message_____ or Phone Call _____

Do you have an email address? **Y / N**
If so, may our providers contact you at that address with possible medically sensitive details? **Y / N**
Please provide your email address by **printing clearly on the line below:**

_____

Email Address

Would you like to receive a monthly E-Mail newsletter from our office letting you know of upcoming events at the Atkinson Building, along with informative healthcare topics? Y / N

Due to HIPAA regulations, we may only discuss health information with people that you have listed below (*that includes parents and/or spouses*). Please list **all people** that we may speak to about you and your medical status.

NAME	PHONE NUMBER	RELATION TO PATIENT
Dragonfly Collaborative Care Group—for medical/behavioral collaboration as appropriate		

Please note that this consent will be valid for one year (from date signed)*****. If your contact information changes before the end date, please complete a new form. This may be revoked at any time, in writing. The information is for your protection and we appreciate your cooperation in protecting you and your rights.

_____ *****Date:_____

Patient/Legal Representative Signature ***Valid for one year from this date***